BLACKBURN WITH DARWEN, BLACKPOOL AND LANCASHIRE CHILDREN'S SAFEGUARDING ASSURANCE PARTNERSHIP

Concealed and Denied Pregnancy Guidance

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Version 1

Contents

1. Introduction and Purpose

1.1 Following the number of Serious Case Reviews (SCR's) in Lancashire that featured a concealed or denied pregnancy, data was collated of women who booked their pregnancy after 24 weeks. This data was analysed over a 12 month period.

Lancashire data highlights that

- There was 1 case of a concealed pregnancy in every 143 births (0.69%)
- 22% of these women concealed their pregnancies right up to the birth of their baby.
- In 1 in every 654 (0.15%) births, women concealed their pregnancy up to giving birth.
- 74% of women concealing or denying their pregnancy were aged between 18-29 years.
- 7% of those concealing or denying their pregnancy were under 18 years of age.
- The reasons women gave for their late booking or concealments mirrors the evidence in the literature as does the data surrounding vulnerabilities which were identified by professionals.
- 22% of the women who concealed and denied their pregnancies during this period of data collection were already known to children social care.

1.2 This guidance is for anyone who may encounter a woman who conceals the fact that they are pregnant, where there is a known previous concealed pregnancy; or where a professional has a suspicion that a pregnancy is being concealed or denied.

1.3 The purpose of this guidance is to understand the mediators that make women fearful of disclosing a pregnancy. Tighe (2018) suggests that this fear impacts on a woman's freedom (autonomy) and capacity (agency) to act. Women who conceal their pregnancies can experience complex trauma and psychological distress, their pregnancy may not always be a welcome experience and it may represent a crisis for women who perceive it as a stressor (Murphy, Tighe & Lalor, 2015). The paralysing fear, complex emotions and thought processes women experience explain coping mechanisms of avoidance rather than psychopathology, and therefore avoidance can be defined as a mechanism or way of coping (Tighe 2018)

1.4 The concealment and denial of pregnancy will present a significant challenge to professionals in safeguarding the welfare and wellbeing of the

foetus (unborn child) and the mother. There may be a number of reasons why a woman may conceal or deny their pregnancy, for example;

- The pregnancy may have been a result of a sexual assault or abuse and/or exploitation
- The impact of Childhood trauma and developmental trauma
- Fear, for example in situations of domestic abuse, forced marriage, Female Genital Mutilation, honour-based abuse, victims of exploitation, victims of trafficking or modern slavery or child protection surveillance processes
- Shame or embarrassment due to stigma or fear through cultural or family expectations and expected social structures.
- In rare occasions the woman may truly be unaware they are pregnant this may be due to either age, learning disability or another factor

1.5 Understanding the circumstances that make women fearful of disclosing a pregnancy enable practitioners to provide a supportive model of care where women feel safe to reveal (Tighe 2018). Women who consciously conceal and hide their pregnancy, will do so for what they believe to be a 'valid reason' (Murphy-Tighe 2014). Keeping the pregnancy secret and hidden therefore is a coping mechanism (Murphy Tighe & Lalor 2016) but also increases the recurrence of concealed pregnancy (Thynne et al 2012)

1.6 While concealment and denial, by their very nature, limit the scope of professional help, better outcomes can be achieved by coordinating an effective inter-agency approach. This approach begins when a concealment or denial of pregnancy is suspected or in some cases when the fact of the pregnancy (or birth) has been established. This will also apply to future pregnancies where it is known or suspected that a previous pregnancy was concealed or denied.

2. Definitions

2.1 For the purpose of this guidance any reference to an expectant mother includes females of childbearing capacity (including under 18's). A pregnancy will not be considered to be concealed or denied for the purpose of this guidance until it is confirmed to be at least 24 weeks

2.2 A **concealed pregnancy** is a complex, multidimensional and temporal process where a woman is aware of their pregnancy and copes by keeping it secret and hidden. The consequences of a concealed pregnancy are a significant public health issue and safeguarding concern (Tighe & Lalor 2016)

2.3 The denial of pregnancy is the non-recognition of the state of the current pregnancy by a pregnant woman. Denial of pregnancy has been explored in some depth by psychologists and subcategorized accordingly. In contrast to concealment, with denial of pregnancy, the mother may be completely unaware of their pregnancy symptoms, the so-called **pervasive denial**. They may have some physical awareness of their pregnancy, though does not express emotions normally associated with being pregnant and does not prepare for delivery, also known as **affective denial**. In other circumstances the mother may suffer from a psychotic disorder, the appropriately termed **psychotic denial** (Stenton & Cohen 2020). Psychotic denial of pregnancy may occur in women with psychosis and a history of loss of custody of other children (Friedman et al 2011) and the possibility of experiences of trauma and the unknown impact of such trauma.

2.4 Women can make choices about their pregnancy. Healthcare professionals should assure themselves that women who choose not to access antenatal care are doing so after receiving the appropriate information from a midwife or medical practitioner to ensure the woman is making an informed decision and determines that the woman has the mental capacity to do so (MCA, 2005). The welfare of the child is paramount, and professionals have a duty to ensure the mothers vulnerabilities and the risk to the child are considered if the woman does not wish to access antenatal care.

2.5 In some organisations late booking may be considered earlier than 24 weeks. The Pan Lancashire pre-birth protocol may be considered at 16 weeks where a pregnancy has been confirmed and there are significant safeguarding concerns, including a previous concealed pregnancy. However, by the very nature of concealment or denial it is not possible for anyone suspecting an expectant mother is concealing or denying a pregnancy to be certain of the stage the pregnancy is at.

3. Evidence from Research and Serious Case Review (updated 2020)

3.1 Research into concealment and denial of pregnancy is relatively recent and has attempted to understand the characteristics of women who conceal or deny their pregnancy. The research highlights that women who conceal their pregnancies have no clear typology (Chen et al 2007) and come from all social classes, irrespective of age, educational or marital status (Hatters Friedman et al 2007, Wessel et al 2007). Women who conceal or deny their pregnancy are often mischaracterised as primiparous teenagers with poor support systems and lack of long-term partnerships. However, Stenton & Cohen (2020) found

that more than half of the women in their study were in long term relationships and nearly one third had had a previous pregnancy.

3.2 Denial of pregnancy is an important condition that is more common than expected, with an incidence at 20 weeks gestation of approximately 1 in 475. The proportion of cases persisting until delivery is about 1 in 2500, a rate similar to that of eclampsia. Denial of pregnancy poses adverse consequences including psychological distress, unassisted delivery and neonaticide (killing of a child by a parent in the first 24 hours following birth). It is difficult to predict which women will develop denial of pregnancy. (Jenkins et al, 2011)

3.3 The issue of concealment and denial of pregnancy, and infanticide/filicide (the killing of a child by a parent) can be evidenced throughout human history. Several studies (Earl, 2000); (Friedman S. M., 2005); (Vallone, 2003) (Tursz and Cook, 2010) highlight a well-established link between neonaticide and concealed pregnancy. A review of 40 Serious Case Reviews (DH, 2002) identified that one death was significant to concealment of pregnancy.

3.4 One study suggests that denial of pregnancy can be linked to trauma and risk factors such as rape, PTSD (post-traumatic stress disorder) and complex PTSD. The trauma can come from an early attachment trauma, a history of physical and sexual abuse as well as trauma associated with the conception of the denied pregnancy, or a combination (Kenner, Nicholson, 2015).

3.5 Local Safeguarding Children Boards (LSCB'S) have conducted safeguarding reviews of cases where concealment or denial of pregnancy has been identified as a factor in the death or serious injury of a child (Murphy, Tighe & Lola, 2015). A review of serious case reviews across Lancashire has highlighted similar themes and missed opportunities such as identifying the importance of concealed pregnancy and the negative impact this has had on the infants, their mother and the family (LSCB, 2018).

3.6 Data around the frequency of concealment or denial of pregnancy is not freely available but does appear within the literature.

Wessel (2002) found 1 case of denied pregnancy in 475 births. Subsequent studies suggest that 1 might occur in about 1:2500 cases (0.04%). A study by Friedman (2007) showed a higher proportion with 0.26% of all pregnancies in their sample of approx. 31,000 women to be concealed or denied. The characteristics of those in this study showed that 50% of those concealing the pregnancy and 59% of those denying the pregnancy were aged between 18 and 29 years. Only 40% of those concealing and 23% of those in denial of their pregnancy were under 18 years of age.

4. Implications of Concealed or Denied Pregnancy

4.1 The implications of concealment and denial of pregnancy are wide-ranging. Concealment and denial can lead to a fatal outcome, regardless of the mother's intention. Several serious case reviews have taken place in Lancashire where children have died as a result of abuse or neglect and in which concealed or denied pregnancy was a contributing factor. Stenton and Cohen (2020) performed the first retrospective review of all coronial post-mortems performed between 2003 and 2018 on infants and foetuses with a history of concealment or denial of pregnancy. Out of 20 cases 15 of the births took place at the mother's home with no medical professional present, 11 infants were said to be born with no signs of life and three were born in poor condition. In five of cases the cause of death could not be ascertained as the baby's body was found abandoned and the mother could not be traced.

4.2 Current guidance in the UK is that all pregnant women should have their first antenatal appointment with a midwife by 10-12 weeks of completed pregnancy and that all routine antenatal screening should be completed by 21 weeks gestation (NICE 2008). Lack of antenatal care can mean that potential risks to mother and child may not be detected. The health and development of the baby during pregnancy and labour may not have been monitored or foetal abnormalities detected. It may also lead to inappropriate medical advice being given, such as potentially harmful medications prescribed by a medical practitioner unaware of the pregnancy.

4.3 Underlying medical conditions and obstetric problems will not be revealed if antenatal care is not sought. An unassisted delivery can be very dangerous for both mother and baby, due to complications that can occur during labour and the delivery. A midwife should be present at birth, whether in hospital or if giving birth at home.

4.4 In addition to the health and wellbeing of the mother, another implication of concealed or denied pregnancy is the lack of willingness or ability to consider the baby's health needs, or lack of emotional bond with the child following birth. In a case of a denied pregnancy, the effects of going into labour and giving birth can be traumatic. It may indicate that the mother has immature coping styles or is simply unprepared for the challenges of looking after a new baby. This also highlights missed opportunities to provide support to women and their babies and avoid serious harm or death to infants in some cases.

5. When a Concealed or Denied Pregnancy Is Suspected

5.1 This section outlines actions to be taken when a concealed or denied pregnancy is suspected (see Section 2, Definition).

5.2 Research suggests a high index of suspicion for pregnancy and its associated complications is required when working with women of childbearing age regardless of their contraceptive history. All professionals should maintain professionally curious when working with this cohort. (Stammers et al, 2014). Health professionals should have a low threshold for pregnancy testing in women of childbearing age who present with symptoms compatible with pregnancy. In one study 38% of women had visited the GP whilst pregnant without receiving a diagnosis of pregnancy (Jenkins, 2011).

5.3 If a pregnancy is suspected of being concealed or denied, the expectant mother should be strongly encouraged to go direct to a midwife, to their GP or to access ante-natal care. If the expectant mother accesses their GP, the GP practice will help them to register with midwifery services for ultrasound scanning and advice about pregnancy and birth. Likewise, referrals and signposting can also be made to unplanned pregnancy services if the woman does not wish to continue with the pregnancy (see section 16). Primary Care should also familiarise themselves with continuing pregnancy policies for unplanned pregnancy services (see section 6.1).

5.4 Professionals must balance the need to maintain confidentiality and the potential concern for the unborn child and the mother's health and wellbeing.

5.5 The GDPR (General Data Protection Regulation) and Data Protection Act 2018 do not prevent, or limit, the sharing of information for the purposes of keeping children and young people safe. Where possible, share information with consent, under the GDPR and Data Protection Act 2018 you may share information without consent if, in your judgement, there is a lawful basis to do so, such as where safety may be at risk.

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5.6 Where there is strong suspicion of a concealed or denied pregnancy, it is necessary to share this irrespective of whether consent to disclose can be obtained or has been given. In these circumstances the welfare of the unborn child and pregnant woman will override their right to confidentiality.

5.7 It may be necessary to make a referral to Children's Social Care about the unborn child - see Making Referrals to Children's Social Care Procedure and Pan Lancashire Pre Birth Protocol. A referral to Adult Social Care may be required if the mother has care and support needs.

5.8 If the expectant mother is under 18 years, consideration will be given to whether a CSC assessment is required. It must not be forgotten that where the mother is under 18, they may also be considered a Child in Need or Child in Need of Protection.

5.9 Where the mother is, or may have been at the time of conception, under the age of 18, professionals should follow the processes outlined in Sexually Active Young People Under the Age of 18 procedure. In addition, if they are less than 16 years of age then a criminal offence may have been committed under the Sexual Offences Act 2003.

5.10 In all cases professionals should exercise professional curiosity. Anyone who has concerns about a child's welfare should make a referral to local authority children's social care and should do so immediately if there is a concern that the child is suffering significant harm or is likely to do so.

5.10 Medical professionals need to consider Gillick competency if a young person under the age of 16 wishes to receive treatment without their parents' or carers' consent or, in some cases, knowledge (NSPCC, 2020)

5.11 The reason for the concealment or denial of pregnancy will be a key factor in determining the risk to the young person or newborn baby and may not be apparent until there has been a multi-agency assessment. If there continues to be a denial of an obvious or confirmed pregnancy, consideration must be given at the earliest opportunity for a referral to CSC to enable the expectant mother to access appropriate mental health services for an assessment if required. Advice can be sought internally from the designated safeguarding lead, from the Named Safeguarding nurse/ Safeguarding Team, named Midwife or Children's Social Care.

5.12 Legal advice and consideration about concealment and denial of pregnancy may be available to protect the health of a pregnant woman and the unborn child, where there is a concern about the ability to make an informed decision about proposed medical treatment, including obstetric treatment. The Mental Capacity Act 2005 states that a person must be assumed to have capacity unless it is proven that they do not. A person is not to be treated as unable to make a decision because they make an unwise decision. It may be that a pregnant woman denying their pregnancy is suffering from a mental illness and this is considered an impairment of mind or brain, as stated in the act, but in most cases of concealed and denied pregnancy this is unlikely to be the case.

5.13 There are no legal means for a local authority to assume Parental Responsibility over an unborn baby. Where the mother is a child and subject to a legal order, this does not confer any rights over their unborn child or give the

local authority any power to override the wishes of a pregnant young person in relation to medical help.

6. When a Concealed or Denied Pregnancy Is Revealed or Confirmed

This section outlines actions to be taken when a concealed or denied pregnancy is revealed by the expectant mother, by the birth of a baby or confirmed by a clinical assessment.

6.1 Midwifery services or unplanned pregnancy services will often be the primary agency involved with an expectant mother after the concealment is revealed, late in pregnancy or at the time of birth. However, it could be one of many agencies or individuals that an expectant mother discloses to or in whose presence the labour commences. It is vital that all information about the concealment or denial is recorded and shared with relevant agencies to ensure the significance is not lost and risks can be fully assessed and managed.

6.2 Continuing an unintended concealed pregnancy can have a serious detrimental impact. Research found that continuing unintended/unwanted pregnancies resulted in higher risk of mental health issues in women, including antenatal and postnatal depression, self-harm, suicidal ideation and attempts, neglectful parenting and poor psychological adaption to parenthood (Global Doctors for Choice Network, 2011, Academy of Medical Royal Colleges, 2011). It is vital that unplanned pregnancy services therefore work collaboratively with maternity services and primary care.

6.3 When a concealment of a pregnancy is revealed in the community *and a birth is suspected* - immediate steps should be taken to confirm the whereabouts and well-being of the baby/foetus. The actions required in this situation will be a police and ambulance response via a 999 call made by the professional/agency who has the information.

6.4 Where a pregnancy is revealed it is vital the circumstances in each case are explored with the expectant mother to fully understand the reasons why the pregnancy has been concealed or denied so that appropriate support and guidance can be offered. This should include a clear understanding, where possible, of the expectant mother history and life experiences.

6.5 Where risks are identified as a result of a concealed or denied pregnancy, appropriate referrals should be made to relevant agencies, for example Mental Health services or Children Social Care (refer to pre-birth protocol). It is important for professionals to recognise that concealment or denial of pregnancy and the subsequent birth can be a traumatic experience for the mother. If consent for referral to mental health services is declined initially this should be offered at future contacts.

7. Educational Settings

7.1 In many instances staff in education settings may be the professionals who know a young person best. There are several signs to look out for that may give rise to suspicion of concealed pregnancy:

- Increased weight or attempts to lose weight
- Wearing uncharacteristically baggy clothing
- Concerns or disclosures expressed by friends
- Repeated rumours of pregnancy around school or college
- Uncharacteristically withdrawn or moody behaviour
- Missing from home or education
- Child exploitation

7.2 Staff working in educational settings, should try to encourage the pupil to discuss their situation, through normal pastoral support systems, as they would any other sensitive issue. Every effort should be made by the professional suspecting a pregnancy to encourage the young person to obtain medical advice. However, where they still face total denial or non-engagement further action should be taken. **The Designated Lead Person for Safeguarding must be informed**.

7.3 Consideration should be given to balance any need to preserve confidentiality and the potential concerns for the mother and unborn baby's health and wellbeing. Where there is a suspicion that a pregnancy is being concealed it is necessary to share this information with other agencies, irrespective of whether consent to disclose can be obtained. When a mother is under the age of 18 years, or an adult with care and support needs safeguarding concerns for the mother should also be considered and acted upon. See also Gillick Competency section 5.10.

7.4 Prior to staff discussing concerns around a concealed or denied pregnancy with the parents of the young person a safeguarding risk assessment should be undertaken. It may be felt that the young person will not admit to their pregnancy because they has genuine fear about their parent's/carer reaction, or there may be other aspects about the home circumstances that give rise to concern, such as sexual or domestic abuse, exploitation, honour based abuse, forced marriage and FGM. If this is the case, then a referral to Children's Social Care should be made without speaking to the parents/carers in the first instance – for further information see Making Referrals to Children's Social Care Procedure

7.5 If there is a lack of progress in resolving the matter in the setting or escalating concerns that a young person may be concealing or denying they are pregnant, there must be a referral to Children's Social Care. It must not be forgotten that where the mother is under 18, they may also be considered a Child in Need or Child in Need of Protection. Where there are significant concerns regarding the girl's family background or home circumstances, such as abuse or neglect, negative childhood experiences of being parented, risk of/victim of exploitation, a history of missing from home and/or education, a referral should be made immediately. As with any referral to Children's Social Care, the parents/carers and young person should be informed, unless in doing so there could be significant concern for their welfare or that of their unborn child.

8. Early Help

8.1 Staff working in an Early Help environment may come across or suspect a concealed or denied pregnancy in a young person, or in a woman of a family they are working alongside. Staff should use professional curiosity and try to encourage the person to discuss their situation with them if they suspect concealed or denied pregnancy. Every effort should be made by the professional suspecting a pregnancy to encourage the person to obtain medical advice. However where they still face total denial or non-engagement further action should be taken and safeguarding policies and procedures followed. It must not be forgotten that where the mother is under 18, they may also be considered a Child in Need or Child in Need of Protection.

8.2 Consideration should be given to the balance of need to preserve confidentiality and the potential concern for the unborn child and the mother's health and wellbeing. Where there is a suspicion that a pregnancy is being concealed it is necessary to share this information with other agencies, irrespective of whether consent to disclose can be obtained.

8.3 Early Help involvement is likely to be beneficial and may include (Local services may differ)

- Early Help Assessment and offer of support and practical help regarding preparing for birth, parenting skills and other routine family maintenance and coping mechanisms.
- Referral to services for emotional health and wellbeing support
- Regular team around the family meetings bringing agencies together

8.4 If Early Help Services engage with the young person's parents/carers they need to consider the possibility of the parent's collusion with the

concealment. Whatever action is taken, whether informing the parents or involving another agency, the young person should be appropriately informed, unless there is a genuine concern for the wellbeing of the mother and their unborn baby. In cases where there is a lack of progress refer to paragraph 7.5.

9. Health Professionals

9.1 Commissioners of health services are responsible for ensuring all its commissioned providers of health care fulfil their statutory responsibilities for safeguarding children and adults at risk. Likewise, providers of healthcare are also responsible for ensuring they fulfil their statutory duties for safeguarding.

9.2 The health professionals who may be involved include:

- Paediatric staff in hospitals
- A&E/ Emergency department staff
- Health Visitors
- School nurses
- Sexual Health and GUM services
- General Practitioners and Practice nurses (Section 10)
- Midwives and Obstetricians/Gynaecologists (Section 11)
- Mental Health Nurses
- Substance Misuse services
- Learning Disability workers
- Psychologists and Psychiatrists
- SUDC (Sudden or Unexpected Death in Childhood) Nurses
- Ambulance service (Section 14)
- Commissioned unplanned pregnancy services (Section 15)

This is not an exhaustive list.

9.3 If a health professional suspects or identifies a concealed or denied pregnancy and there are significant concerns for the welfare of the unborn baby, they must refer to Children's Social Care - see Making Referrals to Children's Social Care Procedure / pre-birth protocol - and inform all the health professionals, including the General Practitioner, involved in the care of the woman.

9.4 If at the point of the discovery of a concealed pregnancy there are suspicions the birth may have already taken place – **Immediate steps need to be taken to confirm the whereabouts and well-being of the baby/fetus. The actions required will be to inform police and ambulance via a 999 response by the health professional who has the information.**

9.5 Accident and Emergency (A&E, ED, Urgent Care) staff or those in radiology departments need to routinely ask women of childbearing age whether they might be pregnant. If suspicions are raised that a pregnancy may be being concealed, these staff should follow safeguarding procedures (section 5) or revealed (section 6).

9.6 Health professionals who provide help and support to promote children's or women's health and development should be aware of the risk indicators and how to act on their concerns if they believe a woman may be concealing or denying a pregnancy.

9.7 GP practices should adopt a flagging system and record the concealed pregnancy on both the mothers and baby's notes. Once born the child should also have this information recorded on their record as it is relevant in future safeguarding decision making.

9.8 Research suggests there is often a poor outcome with post-partum emotional disturbance and increased risk of abuse, neglect, or infanticide (Jenkins et al, 2011). Further research is required to understand the impact of concealed or denied pregnancy on maternal/ infant attachment. There should be extra vigilance by health professionals (midwives, health visitors, GPs) in the post-natal period to monitor mental health and mother - infant relationships and referrals made to mental health and/ or perinatal mental health services (Murphy et al, 2015).

9.9 All health professionals should practice professional curiosity and consider the need to make or initiate a referral for a mental health assessment at any stage of concern regarding a suspected or revealed concealed or denied pregnancy.

10. Primary Care

10.1 Staff in primary care should remain professionally curious when seeing women that appear pregnant but are not accessing antenatal care. This is particularly important if the woman has known vulnerabilities, has a history of a concealed or denied pregnancy, and/or is known to children social care themselves or for any of their children in their care or previously in their care.

10.2 Women known to have sought abortion care are particularly vulnerable if they have had to continue the pregnancy for whatever reason. As such a woman continuing their pregnancy after seeking abortion care, must be considered as a possible higher risk pregnancy. Primary care should therefore have robust systems and processes in place to ensure women continuing their pregnancy receive the appropriate healthcare and support whilst they are

pregnant to ensure the welfare of the unborn baby remains paramount. (See section 16 Pregnancy Advisory Services)

11. Midwives and Midwifery Service

11.1 If an expectant mother presents to Maternity services late in pregnancy but before 24 weeks then midwives should exercise their professional curiosity to ascertain why they have booked late and refer to Children's Social Care if any safeguarding concerns are identified.

11.2 If an appointment for antenatal care is made beyond 24 weeks, the reason for this must be explored. If an exploration of the circumstances suggests a cause for concern for the welfare of the unborn baby, a referral to Children's Social Care must be made - see Making Referrals to Children's Social Care Procedure / pre-birth protocol. The expectant mother should be informed that the referral has been made, the only exception being if there are significant concerns for their safety or that of the unborn child.

11.3 If an expectant mother arrives at the hospital in labour or following an unassisted delivery, where a booking for antenatal care has not been made, then an urgent referral must be made to Children's Social Care. If this is in an evening, weekend or over a public holiday then the Children's Social Care Emergency Duty Team must be informed.

11.4 If the baby has been harmed in any way or there is a suspicion of harm, or the child is abandoned by the mother, then the Police must be *informed immediately via 999* and a referral made to Children's Social Care.

11.5 Midwives should adopt a flagging system and ensure information regarding the concealed pregnancy is placed on the child's, as well as the mother's, health records. Following an unassisted delivery or a concealed/denied pregnancy, midwives need to be alert to the level of engagement shown by the mother, and their partner/extended family if observed, and of receptiveness to future contact with health professionals. In addition midwives must be observant of the level of attachment behaviour demonstrated in the postnatal period.

11.6 Neither baby nor the mother should be discharged until they have had full assessment of their needs, including identification of risks and a multi-agency discharge planning meeting held if required. A discharge summary from maternity services to the relevant GP and Health Visitor must report if a pregnancy was concealed or denied or booked late (beyond 24 weeks).

11.7 If the baby is born at home the midwife or ambulance service (which ever professional is present), should ensure the baby is admitted to hospital even if the mother declines their own admission (see 4.3)

12. Children's Social Care

12.1 Children's Social Care / Emergency Duty Team may receive a referral from any source, which suggests a pregnancy is being concealed or denied. Safeguarding processes must be implemented and following further multi agency enquiries a decision on whether a child and family assessment is required.

12.2 This would ordinarily be done by voluntary agreement with the mother, although where the mother's consent is not freely given, consideration should be given to whether there are grounds for seeking an Emergency Protection Order to ensure the baby remains in hospital until the discharge plan is agreed. Alternatively, the assistance of the Police - via Police Protection - may be sought to prevent the child from being removed from the hospital.

12.3 If the baby is born at home the midwife or ambulance service (which ever professional is present), should ensure the baby is admitted to hospital even if the mother declines their own admission (see 4.3)

12.4 Where the expectant mother is under the age of 18, initial approaches should be made confidentially to the young person to discuss concerns regarding the potential concealed or denied pregnancy and unborn child. The woman should be provided with the opportunity to confirm the pregnancy by undertaking appropriate tests or to make plans for the baby. There may be significant reasons why a young person may be concealing a pregnancy from their family and a professional should consider speaking to them alone without their parent/carer's knowledge in the first instance.

12.5 Where there are clear reasons for suspecting pregnancy in the face of continuing denial or concealment, professionals will need to continue to assess the situation with a focus on the needs /welfare of the mother. It must not be forgotten that where the mother is under 18, they may also be considered a Child in Need or Child in Need of Protection. Such a situation will require very sensitive handling.

12.6 Regardless of the age of the expectant mother where there are additional concerns (i.e. in addition to the suspected concealed or denied pregnancy) where risk factors are present, including ongoing/previous child protection concerns, Children's Social Care must undertake an appropriate safeguarding assessment. This could be in the form of further multi agency

enquiries (e.g. MASH Assessment) or if the perceived risks and unmet needs are significant a Child and Family Assessment.

12.7 If an expectant mother has arrived at hospital either in labour or following an unassisted birth when a pregnancy has been concealed or denied, an assessment of risks is made, and Children's Social Care are to undertake an appropriate safeguarding assessment. Children's Social Care will determine the initial level on the Continuum of Need and further multi-agency enquiries will be made. If Children's Social Care are satisfied that the baby is not at risk of significant harm; and the case does not meet thresholds for level 3 interventions, then an initial MASH assessment will be sufficient. If continuing significant risks and higher levels of need are identified a Child and Family assessment will be initiated.

12.8 Where a baby has been harmed, has died or has been abandoned a Section 47 enquiry must be completed in collaboration with the Police and the Pan Lancashire SUDC (Sudden or Unexpected Death in Childhood) Protocol initiated Management of Sudden Unexpected Deaths in Childhood (SUDC)

12.9 In undertaking an assessment the social worker will need to focus on the facts leading to the pregnancy, reasons why the pregnancy was concealed and gain some understanding of what outcome the mother intended for the child.

12.10 Accessing psychological services in concealment and denial of pregnancy may be appropriate and consideration should be given to referring an expectant mother for psychological assessment. There could be several issues for the woman, which would benefit from psychological intervention. A psychiatric assessment might be required in some circumstances, such as where it is thought they pose a risk to herself or others.

12.11 The pathway for psychological or psychiatric assessment, either before or after pregnancy, is the same. A referral should be made using the single point of entry to mental health services and the referral letter copied to the woman's GP. The referral should make clear any issues of concern for the woman's mental health and any issues around their mental capacity.

13. Police

13.1 The Police will be notified of any child protection concerns received by Children's Social Care where concealment or denial of pregnancy is suspected or confirmed. A police representative will be invited to attend the multi-agency Strategy Meeting and consider the circumstances and to decide whether a joint Child Protection investigation should be carried out.

13.2 Factors to consider will be the age of the expectant mother who is suspected or known to be pregnant, and the circumstances in which they are living and to consider whether they are a victim or potential victim of criminal offences. In all cases where a child has been harmed, been abandoned, died, or expected to die it will be incumbent on the Police and Children's Social Care to work together to investigate the circumstances. This will involve the Pan Lancashire SUDC team in the event of a child death or where the prognosis is poor. Where it is suspected that neonaticide or infanticide has occurred then the Police will be the primary investigating agency.

13.3 It must not be forgotten that where the mother is under 18, they may also be considered a Child in Need or Child in Need of Protection.

14. Probation

14.1 All practitioners in probation services who provide services to, or are in contact with women and girls of child bearing age should be aware of the issue of concealed or denied pregnancy and follow this guidance, and own agency safeguarding procedures when a suspicion of concealed or denied pregnancy arises. This could also relate to the partner of a service user who may be concealing or denying a pregnancy.

15. Ambulance Services

15.1 If an ambulance crew attends a female in labour and a concealed or denied pregnancy is suspected or revealed/ confirmed then the patient must be transported to the nearest maternity unit, and a safeguarding concern raised with Children's Social Care through the NWAS Support Centre. If birth has taken place then the mother and baby must be transferred to the local maternity unit. If the baby is born at home the midwife or ambulance service (which ever professional is present), should ensure the baby is admitted to hospital even if the mother herself declines their own admission (see 4.3)

15.2 If at the point of the discovery of a concealed pregnancy there are suspicions the birth may have already taken place – **immediate steps need to be taken to confirm the whereabouts and well-being of the baby/fetus. The actions required will be to inform Police and Ambulance *via a 999 response* by the member of staff who has the information.**

16. Pregnancy Advisory Services

16.1. All Pregnancy Advisory Services that provide abortion services (either directly delivered by NHS services or charities commissioned by the NHS) have a responsibility to safeguard patients at risk of concealed/ denied pregnancy.

16.2. Pregnancy Advisory Services must work with external statutory agencies to notify them of patients who seek abortion care but do not proceed with treatment. This could be for a variety of reasons such as DNA/ WNB (did not attend/ was not brought), cancellations of appointments, scanning over the legal limit.

16.3. This is particularly important for patients who seek abortion care at later gestations (past 19 weeks), who are under the age of 18 and who have safeguarding concerns/ vulnerabilities, who are considered higher risk of concealed/ denied pregnancy.

16.4. Pregnancy Advisory Services must complete external statutory agencies for all possible concealed/ denied pregnancies, this must include at first instance, GP's and maternity services. This is to ensure that patients who do not obtain treatment after seeing abortion care- go on to get appropriate antenatal care even if they appear to have no vulnerabilities.

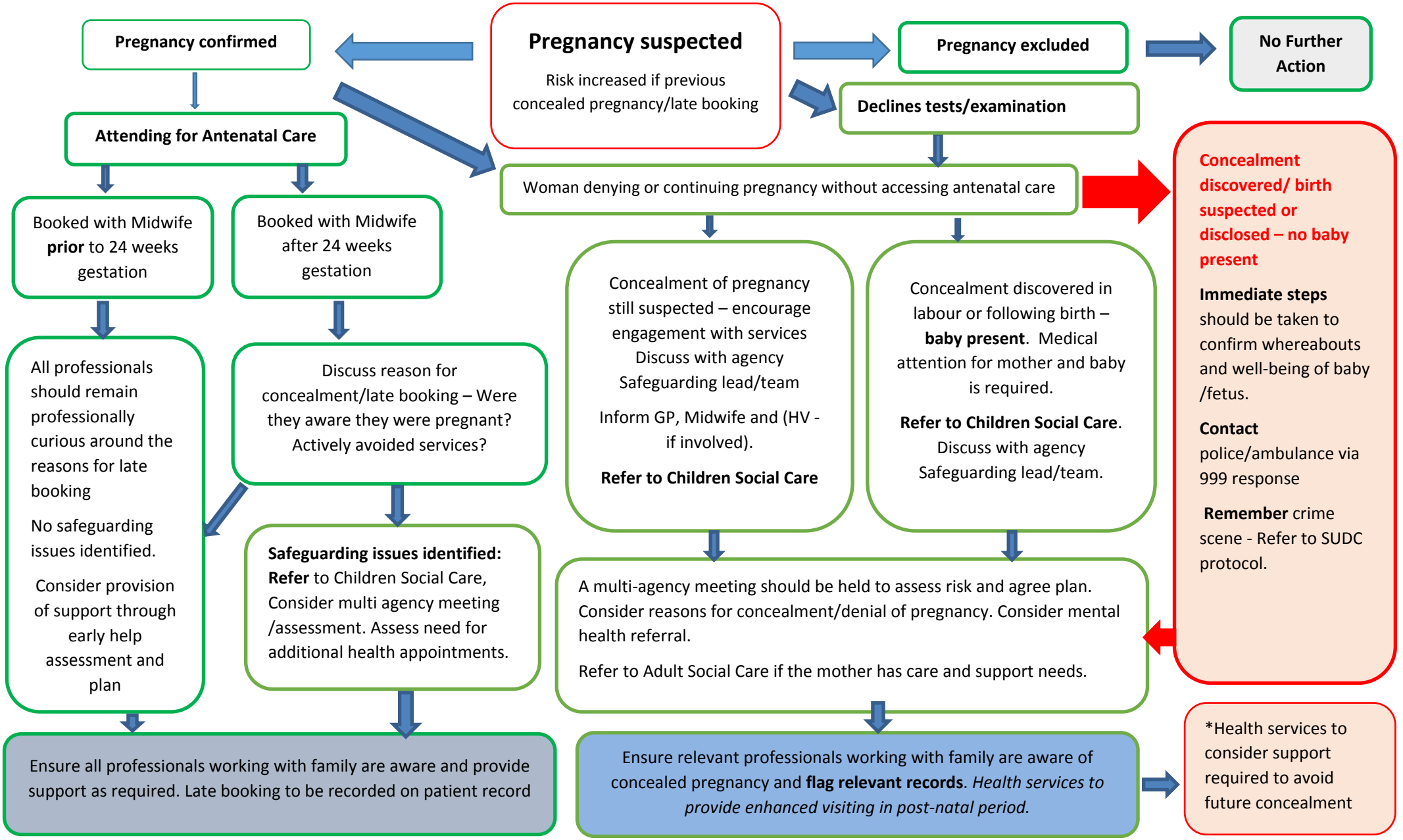
16.5. If the patient has safeguarding concerns, is under 18 years of age or has vulnerabilities, or if GP's or maternity services are unable to make contact with the patient, Pregnancy Advisory Services should ensure that referrals are made to agencies such as social services, school nurses, health visitor and the police to ensure that concealed/ denied pregnancies are appropriately safeguarded.

17. Other Agencies (including the Voluntary Sector)

17.1 All professionals or volunteers in statutory or voluntary agencies who provide services to women of childbearing age should be aware of the issue of concealed or denied pregnancy and follow this procedure when a suspicion arises.

17.2 All referrals will be made to Children's Social Care initially as a referral of an unborn child. It must not be forgotten that where the mother is under 18, they may also be considered a Child in Need or Child in Need of Protection.

Appendix 1 Flowchart



Appendix 2

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Appendix 2

Additional Reading

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